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In The

Supreme Court Of The United States

October Term, 1997

DUARD BOK, MD,

Petitioner,

vs.

MUTUAL ASSURANCE, INC.

Respondent

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Eleventh Circuit

PETITION FOR A WRIT OF CERTIORARI

Jerome Berg
Counsel of Record
Jerome Berg, Esq.
1255 Post Street, Suite 606
San Francisco,
California 94109
(415) 775-7751
Counsel for Petitioner

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QUESTIONS PRESENTED FOR REVIEW

Appellant seeks affirmative interpretation of 42 U.S.C. § 11,101 *et seq.*, the Health Care Quality Improvement Act of 1986 (hereinafter "HCQIA") implying that it authorizes a cause of action to require health care industry peer review to meet its due process provisions.

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PETITION FOR A WRIT OF CERTIORARI

Duard Bok respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Eleventh Circuit.

OPINIONS BELOW

The published opinions of the District Court (App. 2) and Circuit Court of Appeals (App. 7) are appended hereto together with the District Court's order (App. 1) and the denial of a Petition for Rehearing. (App. 12).

I. JURISDICTIONAL STATEMENT

The United States District Court had subject matter jurisdiction based upon 28 U.S.C. § 1331, 28 U.S.C. § 1343 and 42 U.S.C. § 11101, *et seq.* The decision appealed from is a final judgment, which disposed of the action as to all claims by all parties, and is therefore appealable as of right. (See 28 U.S.C. § 1291; Rule 54 of the Federal Rules of Civil Procedure)

Judgment pursuant to Federal Rule of Civil Procedure 12(b)(6) was entered February 22, 1996 (App. 1) and the

memorandum (App. 2) was published at 917 F. Supp. 788.

The United States Court of Appeals for the Eleventh Circuit filed its opinion August 15, 1997, (App. 8) which was published at 119 F.3d 927, and its order denying a Petition for Rehearing and Rehearing En Banc was filed December 12, 1997. (App. 13)

Jurisdiction of the United States Supreme Court is invoked pursuant to 42 U.S.C. § 1254(1).

II. STATUTORY PROVISIONS

This petition concerns the "due process" for peer review portions of the Health Care Quality Improvement Act of 1986 (42 U.S.C. § 11,111 *et seq.*) specifically:

> §11112. Standards for professional review actions
> (a) In general. For purposes of the protection set forth in section 411(a) [42 USCS § 11111(a)], a professional review action must be taken—
> (1) in the reasonable belief that the action was in the furtherance of quality health care,
> (2) after a reasonable effort to obtain the facts of the matter,
> (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and
> (4) in the reasonable belief that the action was

warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3). A professional review action shall be presumed to have met the preceding standards necessary for the protection set out in section 411(a) [42 USCS § 11111(a)] unless the presumption is rebutted by a preponderance of the evidence.

(b) Adequate notice and hearing. A health care entity is deemed to have met the adequate notice and hearing requirement of subsection (a)(3) with respect to a physician if the following conditions are met (or are waived voluntarily by the physician):

(1) Notice of proposed action. The physician has been given notice stating—

(A)(i) that a professional review action has been proposed to be taken against the physician,

(ii) reasons for the proposed action,

(B)(i) that the physician has the right to request a hearing on the proposed action,

(ii) any time limit (of not less than 30 days) within which to request such a hearing, and

(C) a summary of the rights in the hearing under paragraph (3).

(2) Notice of hearing. If a hearing is requested on a timely basis under paragraph (1)(B), the physician involved must be given notice stating—

(A) the place, time, and date, of the hearing, which date shall not be less than 30 days after the date of the notice, and

(B) a list of the witnesses (if any) expected to testify at the hearing on behalf of the professional review body.

(3) Conduct of hearing and notice If a hearing is requested on a timely basis under paragraph (l)(b)-

(A) subject to subparagraph (B), the hearing shall be held (as determined by the health care entity)-

(i) before an arbitrator mutually acceptable to the physician and the health care entity,
(ii) before a hearing officer who is appointed by the entity and who is not in direct economic competition with the physician involved, or
(iii) before a panel of individuals who are appointed by the entity and are not in direct economic competition with the physician involved;
(B) the right to the hearing may be forfeited if the physician fails, without good cause, to appear;
(C) in the hearing the physician involved has the right—
(i) to representation by an attorney or other person of the physician's choice,
(ii) to have a record made of the proceedings, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof,
(iii) to call, examine, and cross-examine witnesses,
(iv) to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law, and
(v) to submit a written statement at the close of the hearing; and
(D) upon completion of the hearing, the physician involved has the right—
(i) to receive the written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations, and
(ii) to receive a written decision of the health care entity, including a statement of the basis for the decision.
A professional review body's failure to meet the conditions described in this subsection shall not, in itself, constitute failure to meet the standards of subsection (a)(3).

§11133. Reporting of certain professional review

actions taken by health care entities
(a) Reporting by health care entities. (1) On physicians. Each health care entity which—
(A) takes a professional review action that adversely affects the clinical privileges of a physician for a period longer than 30 days;
(B) accepts the surrender of clinical privileges of a physician—
(i) while the physician is under an investigation by the entity relating to possible incompetence or improper professional conduct, or
(ii) in return for not conducting such an investigation or proceeding; or
(C) in the case of such an entity which is a professional society, takes a professional review action which adversely affects the membership of a physician in the society, shall report to the Board of Medical Examiners, in accordance with section 424(a) [42 USCS §1134(a)], the information described in paragraph (3).

§11135. Duty of hospitals to obtain information
(a) In general. It is the duty of each hospital to request from the Secretary (or the agency designated under section 424(b) [42 USCS §11134(b)]), on and after the date information is first required to be reported under section 424(a) [42 USCS §11134(a)])]—
(1) at the time a physician or licensed health care practitioner applies to be on the medical staff (courtesy or otherwise) of, or for clinical privileges at, the hospital, information reported under this part [42 USCS §§11131 et seq.] concerning the physician or practitioner, and
(2) once every 2 years information reported under this part [42 USCS §§11131 et seq.] concerning any physician or such practitioner who is on the medical staff (courtesy or otherwise) of, or has been granted clinical privileges at, the hospital.

III. STATEMENT OF THE CASE

A. Background Facts

The abuse of peer review mechanisms to achieve secondary gain at the expense of patients and physicians has been documented in a variety of contexts. See V. Waite and R. Walker, "Medical and Surgical Peer Review," *American Journal of Surgery* 168 (July 1994); B. McCormick, "Managed Care Posing New Liability Risks," *American Medical News*, 13 June 1994, 47-8.

The skimpy record below reflects the misery of a physician who testified before the Select Committee on Children, Youth and Families of the House of Representatives of the one hundred and second Congress of the United States. Dr. Bok described what others also described to Congress, exploitation of young people and adolescents who were held in locked mental health treatment facilities until their insurance was exhausted regardless of their lack of need for this high level of care.

In recent months the extent of this and similar insurance-oriented abusive "treatment" programs have become well

known through newspaper exposés.

The lonely whistleblowers who first brought this horrible situation to the attention of Congress have been blacklisted. In the absence of any contention their care of patients was substandard they are routinely denied malpractice insurance through "peer reviews" about which nothing is told to them, and/or they are denied practice rights in health maintenance organizations and hospital staffs without explanation.[1]

These walking wounded of the battles for decency in the administration of public health benefits provide grim reminders to working health care professionals to turn a blind eye to abuse of patients lest they be initiated into the ranks of the unemployed.

Denying the implied right of suit under the HCQIA to obtain court order for peer review conditions outlined in the HCQIA contributes to wrong side of the health care equation

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[1] Physicians who stand up for patients generally find it a thankless undertaking which frequently results in serious harm to their professional and personal lives. See "Managed Care Contracts of Adhesion, etc." 49 *Rutgers L. Rev.* 1397 (1997)

because it discourages primary care physicians from contesting wrongful administrative practices.

B. Jurisdictional Facts

In his complaint filed September 1, 1996 Dr. Bok alleges that he applied to respondents for insurance. Dr. Bok subsequently met with a "professional peer review committee," not a "traditional insurance underwriting committee." The meeting did not afford Dr. Bok due process. To begin with, petitioner was not advised that a professional review action was being undertaken. Due process requirements listed in 42 U.S.C. §11112 were not met.

Paragraph 20 of the complaint alleges respondent is a creature of the state medical association and "interlocked" through the medical association with the state licensing board.

Paragraph 20(C) alleges monopolistic power of respondent to keep licensees from employment, and ¶ 20(d) asserts inferentially his "peer review impacts access to hospital staff practice rights."

Paragraph 24 asserts that appellant is a well-known "whistle blower" against a fraudulent corporate health care provider, and the next paragraphs allege a conspiracy to restrain his right to earn a living.

The complaint goes on to seek an order for fair peer review pursuant to the due process standards of the HCQIA listed above in the statutory provisions.

IV. REASONS FOR GRANTING THE PETITION AND DISCUSSION

A. The Question Presented is Important

The HCQIA has received relatively little judicial consideration in the dozen years since it was passed, and most of the cases (which are anti-trust suits) went against the doctors.

Petitioner argues that to achieve its purpose (improvement of health care) the HCQIA needs to be interpreted to authorize a private right of action to affected physicians who seek fair peer review.

Among health care attorneys it was generally

understood that the HCQIA, ". . . established federal guidelines for effective peer review." See the discussion in 73 *North Dakota Law Review* 477, 478 (1997) by Murray G. Sagsveen, Esq., general counsel for the North Dakota Medical Association.

Comments in law reviews include, "to safeguard the reputation of the peer review process and encourage physicians to respect and participate in the process, the HCQIA established specific due process requirements that professional peer review must follow." "The New Rules of Show and Tell," etc. 49 *Baylor Law Review* 607, 611 fn. 16 (1997).

Shortly after the HCQIA's enactment the American Hospital Association convened a task group of lawyers and others which issued a fair peer review guide which was intended to assure compliance with the HCQIA's peer review standards. So did a committee of the American Bar Association. Those guides were presented to the district and circuit courts in a Request for Judicial Notice (Fed. Rules of Ev. Rule 201) to show the industry's view that the HCQIA provided a national framework for due process in peer review.

B. The Circuits Are Divided

Until the Eleventh Circuit Court's August 15, 1997 opinion there was only a slightly lopsided division among the few courts which considered this issue. Some found there was an implied right of action; most did not. The Eleventh Circuit sided with those who do not find an implied cause of action relying on Hancock v Blue Cross-Blue Shield of Kansas 21 F.3d 373, 374 (10th Cir. 1994) which held that the purpose of the HCQIA is "to ensure professional peer review of physician competence."

Petitioner contends that the Hancock analysis is superficial, and it does not take into account the central feature of the HCQIA which is to establish a very expensive data bank which *must* be consulted (§ 11,135) before health care provider organizations can admit physicians to membership if those organizations are going to remain eligible to participate in federally funded health care programs and avoid sanctions. (See 45 CFR 60.7(c) as to settlements and 60.9(c) as to clinical privileges.)

C. The Decision of the Court of Appeals is Erroneous

Petitioner contends that the Eleventh Circuit Court of Appeals overlooked and misapprehended the fundamental purpose of the HCQIA and thus arrived at an erroneous opinion that it is primarily a device to defend anti-trust litigation; it is not. The HCQIA is intended to upgrade health care in America through a central monitoring system that focuses on doctors and encourages good faith peer review. The anti-trust qualified immunity is only one segment of this comprehensive legislation.

V. TESTING A STATUTE FOR IMPLIED REMEDIES

When a federal statute does not expressly provide for a private cause of action, one may be implied. In Court v Ash 422 U.S. 66, 78 (1975) this court articulated four criteria to determine if a private cause of action is implied by a federal statute:

> (l) whether a plaintiff is a member of the class for whose special benefit the statute was enacted; (2) whether there is any indication of legislative intent, explicit or implicit, to create or deny a remedy; (3) whether is would be consistent with the underlying purposes of the

> legislative scheme to imply a remedy; and (4) whether the cause of action is one traditionally relegated to state law in an area basically the concern of the states, so that it would be inappropriate to infer a cause of action based solely on federal law.

Petitioner contends that understanding the primary basis of the HCQIA helps to assess whether the HCQIA implies a remedy for physicians to obtain court orders to assure a fair hearing.

VI. ANALYSIS OF THE HCQIA

The purpose of the HCQIA is stated in § 11101 which is entitled "Encouraging Good Faith Professional Review Activities." Section 1 thereof discusses the "nationwide problems" of "increasing occurrence of medical malpractice" and "the need to improve the quality of medical care" which "warrant greater efforts than those that can be undertaken by any individual state." Section 2 speaks of a "national need to restrict the ability of incompetent physicians to move from state to state without disclosure or discovery of the physician's previous damaging or incompetent performance."

Under the HCQIA a huge National Practitioner Data Bank has been established into which entities which deal with health care providers are required to deposit reports of various activities involving physicians including failures to be admitted to health care provider organizations, and certain medical malpractice settlements and payments. The HCQIA (§ 11,131(c) and the Code of Federal Regulations) establish a $10,000 civil penalty for failure to report. Section 11132 requires boards of medical examiners to make reports of revoked or suspended licensees. Section 11133 requires reports of "health care entities which (A) take[s] a professional review action that adversely affects the clinical privileges of a physician for a period of longer than 30 days." Section (C) requires reporting by professional societies of any act which "adversely affects the membership of a physician in the society."

The health care industry customarily requires practitioners to maintain malpractice insurance as a condition of clinical privileges. The loss of such insurance results in loss of privileges. In fact, this is what occurred in Dr. Bok's case.

Section 11151(1) includes "failing to renew clinical privileges or membership" as a reportable event.

Section 11135 of the HCQIA imposes a duty on hospitals "to request from the Secretary" of Health and Human Services the information in the data bank "(1) at the time a physician . . . applies to be on the medical staff" and "(2) once every two years" thereafter.

The HCQIA's legislative history reported in *U.S. Code Congressional and Administrative News*, 99th Congress, 2d Session 1986 at page 6387 notes the existence of two registries, one maintained by the Federation of State Medical Boards (FSMB), and the other by the American Medical Association (AMA), noting that, "the data collection activities described in this bill would be much more extensive than any that currently exist. Based on rough estimates provided by the AMA, this bill could require approximately one million hospital staff member credential checks per year. In fiscal 1987, it could cost about $30 million to create the comprehensive data base, to operate the system, and to respond to credential check inquiries" and $10 million annually thereafter.

VII. THE IMPLIED REMEDY OF LITIGATION TO ENFORCE GOOD FAITH PEER REVIEW

As shown above, the establishment of a National Practitioner Data Bank which must be consulted before a physician may be made a medical staff member of a hospital and the industry's response to the due process components of the HCQIA imply that the HCQIA must be the national device to level the peer review playing field. The expense of that huge sum of money in establishing and running the National Practitioner Data Bank implies that the data collection system is generating useful information through a system of fair procedures. Absent that element of assurance, the Data Bank must be viewed as an unreliable dust bin containing information of greater or lesser probity depending on the quality of the underlying hearing process, but not sufficiently derived from uniform sources to be a reliable resource for rational decisions.

During the 1986 Congressional debate Representative Waxman expressed Congress' desire to grant immunity to fair peer review but not to monopolistic abuse in these words addressed to the Ninth Circuit Court of Appeals ruling in

Patrick v Burget 88 F.2d 1498 (9th Cir. 1986) reversed 486 U.S. 94, (1988):[2] "Bad faith peer review activities as permitted by the Patrick case could never obtain immunity under [HCQIA]." (Congressional Record October 17,1986, daily edition H11590 at the foot of the first column). This statement contemplates the doctor's right to a fair hearing; it supports the implied right to sue for an order imposing a fair hearing. This Congressional comment can be read to support the Court v Ash (*supra*) points one and two. Several courts have so read Court v Ash in the HCQIA context.

Court v Ash factor three calls attention to the national purpose of the HCQIA -- to provide a due process structure for results which will be fed into the National Practitioner Data Bank.

Factor four asks whether due process for data to be entered in a national system should be governed by a crazy quilt of 50 sets of state rules about what elements make up a fair hearing, or whether we will have a single nation-wide

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[2] See Patrick at note 3 condemning conduct which was "shabby, unprincipled, and unprofessional."

standard.

Factors three and four suggest the importance of nationally uniform standards of due process so that the data reported to the National Data Bank is more or less uniform and therefore reliable and useful to achieve the HCQIA's purpose.

VIII. THE PURPOSE OF THE HCQIA IN CONTEXT

When analyzing the legislative purpose of the HCQIA the court should consider that Congress was aware of the irregular existing pattern of 50 state approaches to fair peer review. (See page 19 hereof.)

Most states declined to regulate the private administrative due process of health care organizations through legislation before New York enacted Public Health Law § 2801-b in 1972, and few have tried since. (Exceptions include California, Colorado, New Jersey, Ohio, Pennsylvania, Virginia and Washington.) Former Texas Rev. Civ. Stat. Ann. art. 4437F, section 17(c), a 1987 Texas statute which required "procedural due process" for each applicant for medical staff membership, was repealed in 1989.

Before enactment of HCQIA, scant concern was given to the impact on the public of the system which permits cartelization of medicine. For example, in Illinois, judicial review of private hospital decisions to terminate or curtail existing medical staff privileges was limited by the "rule of non-review" except to determining whether such decisions were rendered in compliance with the hospital's own bylaws. See Pulido v St. Joseph Memorial Hospital 547 N.E. 2d 1383, 1388 (1989).

The HCQIA's legislative history tells of the committee's deep understanding that there is a lack of uniformity among the state law rules of due process in this field:

> The Committee is aware, for example, that some courts have already carefully spelled out different requirements for certain professional review activities or actions, such as procedures for decision regarding applicants for clinical privileges at a hospital. In those situations, compliance with applicable law should satisfy the "adequacy" requirement even where such activities or actions require different or fewer due process rights than the ones specified under subsection 102(b). In any case, *it is the Committee's intent that physicians receive fair and unbiased review to protect their reputations and medical practices.* The Committee intends that the hearing panel or officer be impartial and fair in evaluating a physician's behavior. In order to

> ensure that reviews of, physicians pertain only to quality of care, the Committee has specified that members of the hearing panel, or the hearing officer, cannot be in direct economic competition with the physician-respondent. The Committee recognizes that in many cases, such as small hospitals or group practice, hospitals or physicians in rural areas, or situations involving highly specialize work, this requirement may present some difficulty. In particular, it may not be feasible to find physicians who are of the same specialty as the respondent but who are not in direct in economic competition. Nevertheless, the Committee expects the professional review body to make every reasonable effort to find appropriate officers or members of the panel, even if this requires bringing in reviewers from out of town or using physicians of different specialty.

(1986 *U.S. Code Cong. & Adm. News* at 6393. Emphasis added.) Notice how comfortably this statement fits the Court v Ash (*supra*) criteria.

The title of the act tells its purpose, "Health Care Quality Improvement Act." The entire thrust of the statute is to benefit society through incentives to the health care industry for development of ethical peer review. The reason was succinctly stated in the California opt-out statute which provides a few more due process elements than the HCQIA:

> Peer review which is not conducted fairly results

> in harm both to patients and healing arts practitioners by limiting access to care.

(California Bus. & Prof. Code §809(a)(4))

In discussing the need for summary suspension of practice rights exceptions when there is a crisis which demands "quick action" to avoid immediate health hazards the Congressional Committee again returns to its due process concern:

> these exceptions are not meant to provide a back door for harassment of physicians through repeated short term suspensions or interminable investigations never leading to a professional review action.

(1986 *U.S. Code Cong. & Adm. News* at 6394)

VII. STATUTORY INTERPRETATION

This court has noted, "'In expounding a statute, we must not be guided by a single sentence or member of a sentence, but look to the provisions of the whole law, and to its object and policy.' [Citations.] Our objective in a case such as this is to ascertain the congressional intent and give effect to the legislative will." Philbrook v. Glodgett 421 U.S. 707, 713 (1975).

Further, in interpreting a statute, this court has emphasized the importance of avoiding: "absurd results" (United States v. Turkette 452 U.S. 576, 580 (1981)); "an odd result" (Public Citizen v. Department of Justice 491 U.S. 440, 454 (1989)); or "unreasonable results whenever possible." (American Tobacco Co. v. Patterson 456 U.S. 63, 71 (1982); Commissioner v. Asphalt Products Co., Inc. 482 U.S. 117,121(1987)) In Griffin v. Oceanic Contractors, Inc., 458 U.S. 564, 571 (1982), this court stated: "[I]n rare cases the literal application of a statute will produce a result demonstrably at odds with the intentions of its drafters, and those intentions must be controlling.... [Citations.]"

It would show little respect for the Congress were courts to suppose that the lawmakers meant to enact an irrational scheme. Cf. John Hancock Mut. Life Ins. Co. v Harris Trust and Sav. Bank 510 U.S. 86 (1993). The court's examination of statutory language is "guided not by a single sentence or member of a sentence, but look[s] to the provisions of the whole law, and to its object and policy." (Internal quotations omitted. Quoting Pilot Life Ins. Co. v Dedeaux 481 U.S. 41, 51 (1987).

Hancock (*supra*) is a wisp of an opinion about the length of the Eleventh Circuit's August 5, 1997 memorandum opinion. Neither digs into the context which gave rise to the HCQIA or expresses the legislative history. Hancock relies on Goldsmith v Harding Hosp. Inc. 762 F. Supp. 187, 190 (S.D. Ohio 1991), but neither opinion discusses the HCQIA's stated purpose of "Encouraging Good Faith Professional Review Activities," and the title of § 11101, "Encouraging Good Faith Review."

The harm to physicians of unfair peer review is well known to the courts and to Congress. It was in response to the unfair peer review reported in Patrick v Burget (*supra*) that the HCQIA was enacted.

The HCQIA was drafted by a committee which reviewed the then-existing repositories of peer review data and found them inadequate.

In Addis v Holy Cross, etc. 88 F.3d 482 (7th Cir. 1996) the court expresses a broader understanding of the HCQIA as "a commitment to the idea that *government* has a role in *promoting responsible self regulation* by the private sector" (emphasis added, at 487). The Addis court correctly viewed

the big picture, and it focused on the "reporting requirements" as one of the elements of a legislative scheme of "incentives . . . designed to encourage doctors to engage in meaningful peer review." (at 485). A private right of action to enforce the HCQIA's due process requirements would further "encourage... meaningful peer review."

Gill v Mercy Hospital 199 Cal. App. 3d 889, 903; 245 Cal. Rptr. 304, 312 (1988) correctly describes the HCQIA's function saying it

> established a national clearing house of medical peer review and malpractice information and provides qualified immunity from certain federal and state laws for peer review actions taken in good faith.

In Pagano v Oroville Hospital 145 F.R.D. 683, 686 (1993) the court was evidently of the belief that there is an implied right of action to require a health care entity to observe the HCQIA's peer review due process provisions.

In Stevenson *et al.* v Howley, MD 95-2619 Lexis 27941 (4th Cir. Oct. 29, 1996) patients sued Hilton Head Hospital alleging their physician was subjected to "unfair and unreasonable peer review." A compromise restored their doctor

to the hospital staff. The implied right of action was not criticized. While this unpublished case is not cited as precedent, it suggests that the 4th Circuit supports the implied cause of action to enforce the HCQIA's due process requirements.

A context review invites the court to contrast the pre-HCQIA standardless peer review process with the post-HCQIA national due process model of the National Practitioner Data Bank collecting roughly uniformly sifted data compared to the unstructured data registries that pre-exist the HCQIA.

X. CONCLUSION

Managed care health systems abuses are reported in almost every edition of our newspapers. Doctors are at the focus of the conflict between health care companies and their patients. In the case at bar a "whistle blower" doctor is being denied fair peer review as a warning to other physicians to go along with the executives who make business decisions about health care often against the best interest of the patients. If the physician has the implied right to sue for a fair hearing the

objective of the statute can be served. That right to sue will result in a better health care delivery system because the doctors will enjoy due process protection when they stand up for the rights of patients.

Improvement of health care quality in America begins with a statute designed to help doctors obtain fair peer review. The HCQIA combines a carrot and stick approach to achieving fair peer review. It carries an implied right to sue for enforcement of its due process provisions. How much of the economic waste, human misery and fraud reported in the press recently in connection with HCA/Columbia would never have occurred if the HCQIA had been correctly interpreted early on? How much similar future harm can be avoided by a clear statement by this court?

XI. PRAYER

Petitioner prays that this matter be accepted by the court for the purpose of bringing all the benefits of the HCQIA to the American public as taxpayers and as patients beginning with due process protection for doctors who stand at the

public's portal to the health care delivery system.

Respectfully submitted,

Jerome Berg
Counsel of Record
1255 Post Street, Suite 606
San Francisco,
California 94109
(415) 775-7751
Counsel for Petitioner

APPENDIX A

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
EASTERN DIVISION

Duard BOK, M.D.,	)
Plaintiff,	)
	) **CIVIL ACTION NO.**
v.	) **95-D-1188-E**
	)
MUTUAL ASSURANCE, INC.,	)
Defendant.	)

JUDGMENT

In accordance with the attached memorandum opinion, it is CONSIDERED, ORDERED and ADJUDGED that defendant Mutual Assurance, Inc.'s motion to dismiss be and the same is heeby GRANTED in favor of said defendant and against plaintiff Duard Bok, MD, and that the plaintiff take nothing by his said suit.

It is further CONSIDERED and ORDERED that all costs herein incurred be and the same are hereby taxed against the plaintiff, for which let execution issue.

DONE this 22nd day of February, 1996.

/s/Ira De Ment
UNITED STATES DISTRICT JUDGE

APPENDIX B

917 F. Supp. 788

Duard BOK, M.D., Plaintiff,

v.

MUTUAL ASSURANCE, INC., Defendant.

Civil A. No. 95-D-1188-E.

United States District Court,
M.D. Alabama,
Eastern Division.

Feb. 22, 1996.

MEMORANDUM OPINION

DE MENT, District Judge.

Before the court is the defendant Mutual Assurance, Inc.'s motion filed October 2, 1995, to dismiss the above-styled case. The plaintiff, Duard Bok, M.D., failed to respond in opposition. After careful consideration of the arguments of counsel, the relevant case law and the record as a whole, the court finds that the defendant's motion is due to be granted.

STANDARD OF REVIEW FOR MOTION TO DISMISS

Pursuant to Rule 12(b)(6) of the Federal Rule of Civil

Procedure, a defendant may move to dismiss a complaint on the ground that the plaintiff has failed to state a claim upon which relief may be granted. A Rule 12(b)(6) motion questions the legal sufficiency of a complaint; therefore, in assessing the merit of a Rule 12(b)(6) motion, the court must assume that all the factual allegations set forth in the complaint are true. See, e.g., United States v. Gaubert, 499 U.S. 315, 327, 111 S.Ct. 1267, 1276, 113 L.Ed.2d 335 (1991); Powell v. Lennon, 914 F.2d 1459, 1463 (11th Cir.1990). Moreover, all factual allegations are to be construed in the light most favorable to the plaintiff. See e.g., Sofarelli v. Pinellas County, 931 F.2d 718, 721 (11th Cir. 1991); see also Brower v. County of Inyo, 489 U.S. 593, 598, 109 S.Ct. 1378, 1382, 103 L.Ed.2d 628 (1989).

On a motion to dismiss for failure to state a claim upon which relief may be granted, the movant "sustains a very high burden."[1] Jackam v. Hospital Corp. of America Mideast, Ltd., 800 F.2d 1577, 1579 (11th Cir. 1986) (citing Currie v. Cayman Resources Corp., 695 F.Supp. 1364,1376 (N.D.Ga.1984)). The Court of Appeals for the Eleventh Circuit has held, "motions to dismiss for failure to state a claim should be denied unless it appears beyond doubt that the plaintiff can prove no set of facts in support of its claims." Jackam, 800 F.2d at 1579 (quoting Bracewell v Nicholson Air Servs., Inc., 680 F.2d 103,

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1 Rule 12(b)(6) of the Federal Rules of Civil Procedure permits a party to plead or move for dismissal of a complaint if that complaint fails to state a claim upon which relief may be granted.

104 (11th Cir.1982)); see also Hishon v. King & Spalding, 467 U.S. 69, 73, 104 S.Ct. 2229, 2232, 81 L.Ed.2d 59 (1984).

The court also stresses that on a motion to dismiss for lack of subject matter jurisdiction, Rule 12(b)(1) of the Federal Rules of Civil Procedure, the nonmoving party has the burden of showing that it properly invoked the court's jurisdiction. Menchaca v. Chrysler Credit Corp., 613 F.2d 507, 511 (5th Cir.), cert. denied, 449 U.S. 953, 101 S.Ct. 358, 66 L.Ed.2d 217 (1980).[2] In ruling on the motion, the court is to "consider the allegations of the complaint as true." Williamson v. Tucker, 645 F.2d 404, 412 (5th Cir.), cert. denied, 454 U.S. 897, 102 S.Ct. 396, 70 L.Ed.2d 212 (1981).

DISCUSSION

The plaintiff brings this action pursuant to the Health Care Quality Improvement Act of 1986 ("HCQIA"), 42 U.S.C.A. § 11101 et seq. As such, the plaintiff alleges in his complaint that this court has federal question jurisdiction over claims brought under 42 U.S.C.A. § 11112. See 28 U.S.C. § 1331.[3] However, the defendant contends that the HCQIA does not provide to the plaintiff a private cause of action. Therefore,

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2 Decisions of the former Fifth Circuit rendered prior to October 1, 1981, constitute binding authority in the Eleventh Circuit. Bonner v. City of Prichard, 661 F.2d 1206, 1209 (11th Cir.1981) (en banc).

3 Section 1331 provides, "[t]he federal district courts shall have original jurisdiction of all civil actions arising under the ... laws ... of the United States." 28 U.S.C. § 1331.

the defendant contends not only that the plaintiff has failed to state a claim upon which relief may be granted, but also that the court lacks subject matter jurisdiction.

In a case factually similar to this case, the Tenth Circuit held that the HCQIA did not create a private cause of action in favor of a physician who was allegedly denied the right to full representation and participation of counsel in a peer review proceeding. Hancock v Blue Cross-Blue Shield of Kansas, 21 F.3d 373 (10th Cir.1994). In Hancock, the plaintiff-physician "based his action on a claim of federal question jurisdiction arising under the [HCQIA]...." Id. The plaintiff-physician, as in this case, specifically claimed he was denied the protections guaranteed under the HCQIA In affirming the district court's dismissal for lack of subject matter jurisdiction, the Tenth Circuit weighed the factors outlined in Cort v Ash, 422 U.S. 66, 95 S.Ct. 2080, 45 L.Ed.2d 26 (1975), and concluded that "Congress did not intend to create a cause of action for the benefit of physicians to enforce provisions of the HCQIA."[4] *Id.*

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[4] As succinctly summarized in Hancock, "the Supreme Court in [Cort v. Ash, 422 U.S. 66, 95 S.Ct. 2080, 45 L.Ed.2d 26 (1975)] noted that there are four factors relevant to the determination of whether a private cause of action may be implied from a statute that does not expressly provide for one . . .:

> (1) whether the plaintiff is a member of the class for whose special benefit the statute was enacted; (2) whether there is any indication of legislative intend, explicit or implicit, to create or deny a remedy; (3) whether it would be consistent with the

at 374. As such, the court reasoned that an implied cause of action does not exist for physicians under the HCQIA *Id.* at 37475. In fact, other federal district courts which have considered this issue have found that the HCQIA does not create a cause of action for physicians. See Doe v. United States Dep't of Health and Human Servs., 871 F.Supp. 808, 812 (E.D.Pa.1994), aff'd, 66 F.3d 310 (3d Cir.1995); Goldsmith v Harding Hosp., Inc., 762 F.Supp. 187, 190 (S.D.Ohio 1991) ("A weighing of the factors set forth in Cort v. Ash leads to the conclusion that Congress did not intend to create a cause of action for the benefit of physicians to enforce the provisions of § 11112 or to sue under other provisions of the HCQIA").

The court is persuaded by the reasoning set forth in the aforementioned authority and finds that none of the relevant Cort v. Ash factors weighs in favor of an implied cause of action in this case. As such, the court finds that the HCQIA creates no cause of action for benefit of physicians to enforce its provisions. Consequently, the court finds that the HCQIA does not provide the plaintiff a private cause of action, and therefore, the court lacks subject matter jurisdiction.

> underlying purposes of the legislative scheme to imply a remedy; and (4) whether the cause of action is one traditionally relegated to state law in an area basically the concern of the states, so that it would be inappropriate to infer a cause of action based solely on federal law."

21 F.3d at 374 (citations omitted).

Accordingly, the defendant's motion to dismiss is due to be granted. A judgment in accordance with this memorandum opinion will be entered separately.

APPENDIX C

119 F.3d 927

Duard BOK, M.D., Plaintiff-Appellant,

v.

MUTUAL ASSURANCE, INC., Defendant.

No. 96-6278

Non-Argument Calendar

United States Court of Appeals,

Eleventh Circuit

Aug. 15, 1997.

PER CURIAM:

The question presented in this appeal is whether or not the Health Care Quality Improvement Act of 1986 (HCQIA), 42 U.S.C. § 1101 et .seq., provides for a private cause of action to a physician who alleges an insurance company violated its provisions when it refused to provide him with medical malpractice insurance after a peer-review proceeding. We find that the Act does not provide for a private cause of action and affirm the dismissal of the complaint.

In his complaint, Bok alleged that Mutual Assurance, Inc., violated the HCQIA's due process requirements when it refused to provide him with medical malpractice insurance

after a peer-review proceeding. More specifically, Bok complained that Mutual Assurance did not, among other things, provide him with notice prior to his peer-review hearing or advise him that he could call witnesses or present evidence at the hearing.

Mutual Assurance filed a motion to dismiss, Fed.R.Civ.P. 12(b)(6), arguing that the HCQIA did not grant Bok a private right of action to sue it. Mutual Assurance relied on, among other cases, an opinion issued by the Tenth Circuit, Hancock v. Blue Cross-Blue Shield of Kansas, 21 F.3d 373 (10th Cir. 1994). Bok did not file a brief in opposition to Mutual Assurance's motion.

The district court, in a memorandum opinion reported at Bok v Mutual Assurance, Inc., 917 F.Supp. 778, 779-80 (M.D.Al. 1996), agreed with Mutual Assurance and relied in part on Hancock to conclude that the HCQIA did not create an express or implied cause of action for Bok to complain about Mutual Assurance's peer-review procedures. The court dismissed Bok's complaint.

Bok argues that the HCQIA implies a private right of action for his suit because components of the HCQIA "level the peer review playing field" by "generating information which is based on fair procedures." Bok also reasons that Congress passed the HCQIA to benefit physicians like him because one section of the act is entitled "Encouraging Good Faith Peer Review." Mutual Assurance argues the district court correctly concluded that the HCQIA did not give Bok an implied cause

of action.

[1] When legislation does not provide expressly for a cause of action for individual plaintiffs, the legislation must provide an implied cause of action in order for individual plaintiffs to be able to sue under the legislation. See Cort v. Ash, 422 U.S. 66, 78, 95 S.Ct. 2080, 2087, 45 L.Ed.2d 26 (1975). In Cort, 422 U.S. at 78, 95 S.Ct. at 2087-88, the Supreme Court formulated four factors for determining whether an implied cause of action exists: l) whether the plaintiff is a member of the class for whose special benefit the legislation was enacted; 2) whether there is any indication of explicit or implicit legislative intent to create a remedy under the act; 3) whether it would be consistent with the underlying purposes of the legislative scheme to imply a remedy; and 4) whether the cause of action is one traditionally relegated to state law.

[2] In the medical profession, peer review is a "process by which physicians and hospitals evaluate and discipline staff doctors[.]" Bryan v. James E. Holmes Regional Medical Center, 33 F.3d 1318, 1321 (11th Cir.1994), cert. denied, 514 U.S. 1019, 115 S.Ct. 1363, 131 L.Ed.2d 220 (1995). The "HCQIA grants limited immunity, in suits brought by disciplined physicians, from liability for money damages to those who participate in professional peer review activities." Id. The HCQIA thus provides that, if the peer review action "meets certain due process and fairness requirements, then those participating in such a review process shall not be liable under any state or federal law for damages for the results." Id. at

1321-22.

In Hancock, the plaintiff-physician sued an insurer alleging that a peer-review panel violated the HCQIA's due-process requirements when it decredentialized him. 21 F.3d at 374. The Hancock court first found that the HCQIA did not expressly create a cause of action in favor of the physician. *Id.* The court next concluded that the HCQIA did not create an implied right of action because it was not enacted for the benefit of physicians subject to peer review, but instead "to ensure professional peer review of physician competence[.]" *Id.* In reaching this conclusion, the court specifically cited the relevant factors from Cort, 422 U.S. at 78, 95 S.Ct. at 2087. Hancock, 21 F.3d at 37475.

[3] This Court reviews *de novo* the district court's conclusions of law. Jones v Childers, 18 F.3d 899, 904 (11th Cir.1994).

[4] Although this Court has not answered whether the HCQIA creates a cause of action for a physician to challenge the procedures used by a peer-review panel, we find the reasoning of the Tenth Circuit in Hancock persuasive and adopt it. We agree, as the Hancock court concluded, that Congress did not pass the HCQIA with the intent of benefiting physicians such as Bok. *Id.* at 374-75. A claim such as Bok's thus fails entirely to satisfy the first Cort factor. See Cort, 422 U.S. at 78, 95 S.Ct. at 2087-88. More importantly, a weighing of the Cort factors also argues against finding an implied cause

of action[5] in the HCQIA. Hancock, 21 F.3d at 374-7a.

[5] As a final note, Bok discusses two matters he did not raise in his filings to the district court: (l) his right to amend his complaint; and (2) his right to discovery. Generally, this Court will not consider issues that the appellant failed to raise below. See Narey v. Dean, 32 F.3d 1521, 1526-27 (11th Cir.1994). Although there are exceptions to this rule, none of them apply in this case. See *id*.

Concluding that the HCQIA does not provide for a private cause of action, WE AFFIRM the judgment of the district court.

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5 There clearly is no express cause of action in the legislation.

APPENDIX D

IN THE UNITED STATES COURT OF APPEALS

FOR THE ELEVENTH CIRCUIT

Filed December 12, 1997

Duard BOK, M.D.,

Plaintiff-Appellant,

versus

MUTUAL ASSURANCE, INC.,

Defendant-Appellee.

On Appeal From The United States District Court For The Middle District Of Alabama

ON PETITION(S) FOR REHEARING AND SUGGESTION(S) OF REHEARING EN BANC

(Opinion _____, 11th Cir., 19_, _ F.2d _).

Before: ANDERSON and BLACK, Circuit Judges, and FAY, Senior Circuit Judge.

PER CURIAM:

The Petition(s) for Rehearing are DENIED and no member of this panel for other Judge in regular active service on the Court

having requested that the Court be polled on rehearing en banc (Rule 35, Federal Rules of Appellate Procedure; Eleventh Circuit Rule 35-5), the Suggestion(s) of Rehearing En Banc are DENIED.

ENTERED FOR THE COURT:

/s/

UNITED STATES CIRCUIT JUDGE

Supreme Court, U.S.
FILED
APR 8 1998
CLERK

No. 97-1456

In The

Supreme Court of the United States

October Term, 1997

DUARD BOK, M.D.,

Petitioner,

vs.

MUTUAL ASSURANCE, INC.,

Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

RESPONDENT'S BRIEF IN OPPOSITION

W. STANCIL STARNES
Counsel of Record
ASHLEY E. WATKINS
STARNES & ATCHISON LLP
Attorneys for Respondent
Seventh Floor, Brookwood Place
P.O. Box 598512
Birmingham, Alabama 35259-8512
(205) 868-6000

145781

(800) 274-3321 • (800) 359-6859
A DIVISION OF COUNSEL PRESS

Lutz Appellate Services, inc.

QUESTION PRESENTED

Whether the Eleventh Circuit Court of Appeals correctly concluded that Petitioner does not have a private right of action under the Health Care Quality Improvement Act, and that the case was therefore due to be dismissed.

STATEMENT PURSUANT TO RULE 29.6

This brief opposing the Petition for Writ of Certiorari is filed on behalf of Mutual Assurance, Inc. Its parent company is Medical Assurance, Inc. Mutual Assurance, Inc. has no nonwholly owned subsidiaries.

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STATEMENT OF THE CASE

This proceeding stems from a case originally filed in the United States District Court for the Middle District of Alabama on September 11, 1995. Petitioner Duard Bok filed a Complaint for declaratory and injunctive relief. He based his claim on an alleged violation of the Health Care Quality Improvement Act of 1986, 42 U.S.C. § 11101, *et seq.*

Respondent Mutual Assurance, Inc. filed a Motion to Dismiss on October 2, 1995. As grounds for the Motion, Mutual Assurance argued that the Health Care Quality Improvement Act did not provide the Petitioner with a private right of action and thus did not provide the court with jurisdiction over the matter.

On February 22, 1996, the district court issued a judgment and memorandum opinion granting the Respondent's motion to dismiss based on the fact that the HCQIA did not provide the Petitioner with a private cause of action, and that therefore the court lacked subject matter jurisdiction over the case.

Petitioner Bok appealed this holding to the Eleventh Circuit Court of Appeals. On August 15, 1997, the Eleventh Circuit affirmed the lower court's holding, finding that Dr. Bok did not have a private right of action under the HCQIA. Petitioner then requested a rehearing and rehearing en banc, and these petitions were denied on December 12, 1997.

REASONS FOR DENYING THE WRIT

1. Numerous courts addressing the issue have held that the Health Care Quality Improvement Act provides no private right of action for a physician in Dr. Bok's position. The district court and Eleventh Circuit were properly presented with only

this narrow issue in the instant proceeding, and both reached the same conclusion. Petitioner seeks to have this Court create a private right of action in a piece of legislation that does not contain such a right.

2. There is no compelling reason to grant this petition. None of the reasons set forth in Supreme Court Rule 10 that would justify a grant of a Petition for Writ of Certiorari is present in the instant case. There is no conflict among the circuit courts. No state court of last resort has decided this issue in a manner which conflicts with other decisions.

Courts addressing the issue have uniformly held that the HCQIA does not provide a private right of action. The Eleventh Circuit's decision does not conflict with decisions of other courts of last resort. *See Hancock v. Blue Cross & Blue Shield of Kansas, Inc.*, 21 F.3d 373 (10th Cir. 1994); *Rogers v. Columbia/HCA of Cent. La., Inc.*, 971 F. Supp. 229 (W.D. La. 1997); *Doe v. United States Dep't of Health and Human Serv.*, 871 F. Supp. 808 (E.D. Pa. 1994), *aff'd*, 66 F.3d 310 (3d Cir. 1995); *Goldsmith v. Harding Hosp., Inc.*, 762 F. Supp. 187 (S.D. Ohio 1991); *Caine v. Hardy*, 715 F. Supp. 166 (S.D. Miss. 1989).

3. None of the reasons for granting the petition as listed by Petitioner would serve as a proper basis for review by this court. Each of the reasons proffered by Petitioner will be addressed separately:

(a) Petitioner claims that the HCQIA has received relatively little judicial consideration in the dozen years since it was passed. However, no fewer than the five courts noted above have considered the precise issue raised by Petitioner, and countless other courts have addressed other parts of the HCQIA since it was enacted.

(b) Petitioner claims that the circuits are divided as to whether the HCQIA affords a physician a private right of action. Tellingly, Petitioner provides no case law to support his assertion. Indeed, he cites only two cases on the topic. First, Petitioner writes that in *Pagano v. Oroville Hosp.*, 145 F.R.D. 683 (E.D. Cal. 1993), the court "was evidently of the belief that there is an implied right of action to require a health care entity to observe the HCQIA's peer review due process provisions." A review of the case reveals that while the case mentioned the HCQIA, the issue presented in the case at bar was not before the California district court. Instead, the court was asked to consider whether the HCQIA provided immunity for the misuse of the peer review process, and whether the Act precluded discovery of documents related to peer review activities. However, the claim at issue in *Pagano* was brought under the Sherman Act, not as a cause of action under the HCQIA. Therefore, *Pagano* does not support Petitioner's position.

Similarly, Petitioner claims that *Stevinson v. Howley*, 99 F.3d 1131 (4th Cir. 1996) is a case which "suggests" that the Fourth Circuit supports an implied right of action under the HCQIA. Again, that issue was never before the *Stevinson* court, and the opinion (which is an unpublished disposition) states that the basis of the suit was an allegation of intentional interference with the doctor-patient relationship. The HCQIA was not implicated until the plaintiffs' claim was dismissed and the defendant doctors sought attorney's fees pursuant to the HCQIA. The case does not hold, suggest or imply that the HCQIA provides a physician with a private right of action.

(c) Petitioner contends that the Eleventh Circuit misunderstood the fundamental purpose of the HCQIA. This case involves only the narrow issue of whether the Act provides the Petitioner with a private right of action. Such a determination

can be made with reference only to the wording of the statute and the guidelines set forth in this Court's decision in *Cort v. Ash*, 422 U.S. 66 (1975), without any consideration of the extraneous factors Petitioners suggests the Court should consider.

This case presents facts similar to those in *Hancock v. Blue Cross & Blue Shield of Kansas, Inc.*, 21 F.3d 373 (10th Cir. 1994). Like the plaintiff in *Hancock*, Plaintiff/Petitioner Bok attempted to base his suit on a claim of federal question jurisdiction under the HCQIA. As in that case, the dismissal of his case is due to be affirmed based on the fact that the Health Care Quality Improvement Act provides him no private right of action in these circumstances.

Petitioner Bok attempted to construct an action around the Respondent's alleged violation of the HCQIA's due process requirements. However, the *Hancock* court noted that "the HCQIA does not *expressly* create a cause of action against a professional peer review group that has violated its due process requirements." *Hancock*, 21 F.3d at 374, citing *Goldsmith v. Harding Hosp., Inc.*, 762 F. Supp. 187 (S.D. Ohio 1991) (emphasis added). Thus, if Petitioner is to base his suit on a violation of the HCQIA, he must establish that the legislation *implies* a private right of action in his favor. He is unable to meet this burden.

The case of *Goldsmith v. Harding Hosp., Inc.*, 762 F. Supp. 187 (S.D. Ohio 1991) addressed the question of whether a private right of action may be implied from the HCQIA. The court noted that in *Cort v. Ash*, 422 U.S. 66 (1975), the Supreme Court established four factors that must be considered when assessing whether a private right of action is implied in a statute:

> 1) whether the plaintiff is a member of the class for whose special benefit the statute was enacted;

> 2) whether there is any indication of legislative intent, explicit or implicit, to create or deny a remedy;
>
> 3) whether it would be consistent with the underlying purposes of the legislative scheme to imply a remedy; and
>
> 4) whether the cause of action is one traditionally relegated to state law in an area basically the concern of states, so that it would be inappropriate to infer a cause of action based solely on federal law.

Id. at 188. The *Goldsmith* court conducted a *Cort* analysis of the same provision of the HCQIA that is at issue in the instant case, and identified several factors that support the conclusion that the HCQIA does not provide a physician with a private cause of action based on a "peer review" proceeding.

First, the court found that the chief beneficiaries of the statute are the professional review bodies that are immune from liability for the results of appropriately conducted peer review proceedings. *Id.* Second, a review of the statute's legislative history revealed no indication that Congress intended to create a cause of action for physicians seeking to compel compliance with the Act. *Id.* at 189. Third, implying a remedy for physicians in this situation would be inconsistent with the overall intent of the Act, which was meant to shield peer review participants from the threat of litigation, not to add an additional potential cause of action against them. *Id.* Finally, the court was satisfied that the issue was one more properly the subject of a state law proceeding. *Id.* at 190.

Other courts addressing this topic have reached the same conclusion. *See Hancock v. Blue Cross & Blue Shield of Kansas,*

Inc., 21 F.3d 373 (10th Cir. 1994); *Doe v. United States Dep't of Health and Human Serv.*, 871 F. Supp. 808 (E.D. Pa. 1994), *aff'd*, 66 F.3d 310 (3d Cir. 1995); *Caine v. Hardy*, 715 F. Supp. 166 (S.D. Miss. 1989). Petitioner admits in his Opening Brief that these decisions exist, and he fails to cite a single case from any court in the country which has found that the HCQIA provides, expressly or by implication, a private right of action in these circumstances. Indeed, no such decision exists.

CONCLUSION

The Petition for Writ of Certiorari should be denied because the case was properly decided based on a careful reading of the Health Care Quality Improvement Act. The Petitioner's objections to the lower courts' decision on the issue does not raise a federal question appropriate for review by this Court. The lower courts involved in the instant case, as well as all courts in the country which have addressed the issue, have been in agreement that the HCQIA does not provide a private right of action which may serve as an independent basis for a lawsuit. Accordingly, Respondent Mutual Assurance, Inc. respectfully requests that the Petition for Writ of Certiorari be denied.

Respectfully submitted,

W. STANCIL STARNES
Counsel of Record
ASHLEY E. WATKINS
STARNES & ATCHISON LLP
Attorneys for Respondent
Seventh Floor, Brookwood Place
P.O. Box 598512
Birmingham, Alabama 35259-8512
(205) 868-6000